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10. CONDITIONS LIMITING ACCEPTANCE OF NEW MEDICAID PATIENTS

9\* indicated they had NO conditions limiting the acceptance of new Medicaid OB patients (1 respondent noted that she refers if the patient is high risk)

1 takes referral from another physician

1\* takes low risk pregnancy

2 indicated "other":

"I don't limit but patient must qualify as appropriate for nurse midwifery care"

\*1 respondent selected two answers as indicated by the \*

11. LIMIT THE NUMBER OF MEDICAID PATIENTS

All 12 respondents indicated that they do NOT limit the number of Medicaid patients they accept into their OB practice

12. PARTICIPATE IN NEW PROGRAM FOR OTHER LOW-INCOME WOMEN

10 respondents indicated they are interested in participating in a new program

1 indicated that the question was not applicable (IHS)

1 indicated that she did not know; it would be up to the physician

\* 3 of the 10 respondents indicating they would be interested in participating are IHS employees

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13. WILLING TO USE STANDARDIZED FORM

6 respondents indicated they are willing to use a  
standardized form provided by the State

1 is not willing to use a state-provided form

4 said it depends on the type of form used

There was 1 NO response.

14. DETERMINATION OF COST FOR OB CARE

5 respondents indicated cost is itemized per visit

3 use itemized cost per visit and global package\*

5 indicated "other"\*

"government" -4 respondents

"we prefer package but found that reimbursers rejected  
this plan even though compliance is better and better  
deal financially"

\*1 respondent selected two answer options indicated by the \*

15. METHOD OF PAYMENT FOR OB CARE FOR LOW-INCOME WOMEN

2 respondents require payment in full at time of office  
visit

3\* bill insurance/Medicaid

5\* depends on ability of patient to pay

3 "not applicable"

\*1 respondent selected two answer options indicated by the \*

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15+. PERCEPTIONS INFLUENCING DECISION TO TAKE MEDICAID PATIENTS  
INTO PRACTICE

\*Responses to this question are on a scale of 1 to 5 with  
one being NOT IMPORTANT AT ALL and 5 being VERY IMPORTANT.  
Please refer to question for description of question.

a. TOO HIGH RISK MEDICALLY

8 respondents selected a rating of "1"  
1 selected a rating of "2"  
1 selected a rating of "3"  
1 selected a rating of "5"

1 respondent indicated the question was not applicable

b. LOW REIMBURSEMENT RATE

4 respondents selected a rating of "1"  
6 selected a rating of "3"  
1 selected a rating of "4"

1- not applicable

c. LENGTH OF TIME TO GET PAYMENT

4 selected a rating of "1"  
1 selected a rating of "2"  
3 selected a rating of "3"  
2 selected a rating of "5"

1- not applicable

1- NO response\*\* [see explanation on pg. 10]

d. TOO MUCH PAPERWORK

4 selected a rating of "1"  
3 selected a rating of "2"  
1 selected a rating of "3"  
2 selected a rating of "5"

1- not applicable

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e. MEDICAID PATIENTS MORE LIKELY TO SUE

7 selected a rating of "1"  
2 selected a rating of "2"  
1 selected a rating of "3"

1- not applicable

1- "I don't believe"

f. DIFFERENT SOCIOECONOMIC BACKGROUND

10 selected a rating of "1"  
1 selected a rating of "2"

1- not applicable

g. DENIAL OF ELIGIBILITY AFTER PATIENT IN CARE

6 selected a rating of "1"  
2 selected a rating of "2"  
2 selected a rating of "3"

1-not applicable

1-no answer\*\*

h. CLIENT NON-COMPLIANCE PROBLEMS

6 selected a rating of "1"  
2 selected a rating of "2"  
2 selected a rating of "3"

1- not applicable

1- no answer\*\*

[\*\* no answer- respondent indicated she does not deal with  
finance and therefore could not answer these questions]

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i. OTHER

"CNM's paid 80% of physician's payment for some OB care."

ADDITIONAL COMMENTS:

"The 4 month lag time between client's application for Medicaid and issuance of coupons & the rigid 6 mos. billing limit from date of service is unworkable."

"I would welcome the opportunity to provide obstetric care to low-income women."

Please Note: There are two questions numbered "15". Survey should be proof-read prior to mailing.

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PEDIATRIC ACCESS

A brief study was completed by the Division of Medical Assistance in March, 1990. Of the 946 M.D.s currently licensed by the Department of Commerce, Division of Occupational Licensing, the Alaska State Medical Association reports 48 are pediatricians in private individual or group practice as of (3/1/90). Neither Occupational Licensing nor ASMA keep data that clearly indicates which other physician specialties devote a significant portion of their practice to the care of infants and children, but ASMA registers members in a category entitled "Family and General" practice; ASMA staff report that they believe more than 80% of the physicians so identifying their practice do regularly provide care to infants and children. In this practice category, ASMA lists 156 physicians individual or group private practice as of 3/1/90.

A previous (1989) data request made to the Division of Medical Assistance resulted in data showing that all of the pediatricians in private practice in Alaska were enrolled as Medicaid providers, but this study did not examine the extent of their billing activity within Medicaid. In 3/90, 15 pediatricians were picked at random and tracked through Medicaid Management Information System reports. All were found to be enrolled and participating "substantially" (that is, billing in excess of \$1000) within State Fiscal Year 1990.

Logic would indicate that examining 100% of the pediatricians in private practice would show some of Alaska's pediatricians to be in group practice, billing under a group provider number and not under their individual provider number. In such a situation, Medicaid payment data would not suffice by itself to demonstrate conclusively that they were substantially participating.

Upon brief examination, it appears that this reservation would apply to a much greater degree to "family and general" practioners who, at least in urban areas, appear to be more likely than pediatricians to engage in group practice. Therefore, sampling and tracing those providers through the Medicaid Payments Records could not conclusively demonstrate the extent to which they participated; since their actual practice is hidden under the group number. Only an individual mail survey similar to those sent to obstetrical providers would be conclusive in this area.

However, a sample of 15 family and general practioners was picked at random from across the state in 3/90. 9 were found to be in individual practice and were enrolled Medicaid providers. 8 were found to be participating "substantually" (over \$1000) in FY90. 5 of the 6 that were found to be in group practice were contacted by phone and they (or their office staff) alleged that they were enrolled and served Medicaid patients without limitations. Time did not allow these allegations to be tested by researching the group practice payment records within the Medicaid payment system.

These sample results, showing a nearly-universal active participation in Medicaid by physicians providing care to infants and children are consistent with subjective impressions of the Divisions' SURS unit staff, the Division's Medical Officer (a pediatrician), and the Division of Public Health Public Health Nurses who regularly refer EPSDT children to all these practitioners

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1990 PAYMENT AND ACCESS ISSUES

During calendar year 1990, payment levels and the level of access of clients remained as described above, except for two changes: There was a marked decrease in the numbers of dentists (who primarily provide EPSDT dental services) participating, particularly in the Kenai Peninsula area south of Anchorage. In this area, children had no access to dental services unless they (and an escort) were transported to Anchorage. In the Fall of 1990, several major pediatric group practices, which had traditionally served large numbers of Medicaid children, reported that they were planning to cease their participation.

The cause of both of these changes was the same: reimbursement of physicians and dentists, using the usual, customary, and prevailing fee profile methodology, had been frozen in 1986 by the state legislature. The effect of this was that providers who were participating in 1985, who had thus been profiled, were being paid less than others who enrolled in 1986 and after. In addition to this inequity, Alaska's cost of living and medical services inflation rate per year during 1985-1990 averaged about 5% per year, so that long-term providers had in fact suffered what amounted to a 20%-25% actual rate decrease during this period because of having frozen rates during an extended period of ever-increasing costs of doing business.

On the advice of the Attorney General's office, the department declared an emergency which posed a threat to the public health and general welfare. Using that declaration, the department adopted emergency regulations, effective January 1, 1991, which based physicians' and dentists' reimbursement upon profiles done on bills accepted for payment between July 1, 1989, and September 30, 1990. These emergency regulations were made permanent April 1, 1991. [They also provide for regular, periodic updating of profiles.]

These regulations decreased many payments to providers who entered the program after 1985, and they also decreased some payments to any provider who performs procedures that are new or were otherwise not performed frequently in 1985 or earlier. Even after adjusting for these decreased payments, Medicaid physicians and dentists are anticipated to receive an anticipated total reimbursement increase estimated at \$7,000,000 to \$9,000,000 in the first full year. Large volume, long-standing pediatric and family medicine practices in particular experienced substantial payment increases.

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